Kentucky Specific Information

This document contains information specific to the State of Kentucky. Please refer to the Provider Reference Guide for general information regarding plan administration.

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1.1 Notice of Updates

Notice of updates published January 1, 2024.

- UnitedHealthcare Dual Complete® (Medicare) (H1889-008) updated effective 01/01/2024.
- UnitedHealthcare Dual Complete® (Medicare) (H6595-004) updated effective 01/01/2024.
- Molina Healthcare Passport Advantage HMO D-SNP (Medicare) (H1799-001) terminated effective 12/31/2023.
- Molina Healthcare Passport Medicare Choice Care HMO (Medicare) (H1799-002) terminated effective 12/31/2023.

1.2 Covered Benefits – Passport by Molina Healthcare (Medicaid)

Benefit Plan(s): M-KY-M20, M-KY-M21

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical and Surgical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.

Eyeglasses (Single, Bifocal and Multi-focal)	▪ 1 unit every calendar year when the recipient has a diagnosed visual condition that:
	  ▪ Requires the use of eyeglasses;
	  ▪ Is within one of the following categories:
	  ▪ Amblyopia;
	  ▪ Post surgical eye condition;
	  ▪ Diminished or subnormal vision; or
	  ▪ Other diagnosis which indicates the need for eyeglasses; and
	  ▪ Requires a prescription correction in the stronger lens no weaker than:
	  ▪ +0.50, 0.50 sphere +0.50, or 0.50 cylinder;
	  ▪ 0.50 diopter of vertical prism; or
	  ▪ A total of two (2) diopter of lateral prism.
	▪ Polycarbonate and scratch coating are covered.
	▪ Tinted lenses are covered when the prescription specifically indicates a diagnosis of photophobia.
	▪ Plano safety glasses are covered when medically indicated for the recipient.
	▪ The following is covered when medically necessary:
	  ▪ Photochromics
	  ▪ Anti-reflective coating
	  ▪ Other lens options
	  ▪ Press-on prism

Eyeglass Replacements	▪ 1 pair every calendar year:
	  ▪ The recipient's eyeglasses are broken or lost during the calendar year; or
	  ▪ The eyeglass prescription for the recipient is changed during the calendar year.
	▪ **To identify replacement materials, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for materials.**

Medically Necessary Contacts	▪ Contact lenses are covered in lieu of eyeglasses when a medical indication prevents the use of eyeglasses.

1.3 Covered Benefits – UnitedHealthcare Dual Complete® (Medicare) (H1889-008)

Benefit Plan(s): UDKYS-DCP

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $300 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply. ▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**
Glaucoma Screening	▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk": ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.4 Covered Benefits – UnitedHealthcare Dual Complete® (Medicare) (H6595-004)

Benefit Plan(s): UDKYS-DC3

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $300 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply. ▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**
Glaucoma Screening	▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk": ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.5 Covered Benefits – UnitedHealthcare Dual Complete® (Medicare) (H6595-003)

Benefit Plan(s): UDKYS-DC4

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $250 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply. ▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**
Glaucoma Screening	▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk": ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.6 Covered Benefits – UnitedHealthcare Community Plan (Medicaid)

Benefit Plan(s): UDKYM-20, UDKYM-21, UDKYM-PG20, UDKYM-PG21

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year.
Necessary Medical and Surgical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.

Eyeglasses (Single, Bifocal and Multi-focal)	▪ 1 unit every calendar year when the recipient has a diagnosed visual condition that:
	  ▪ Requires the use of eyeglasses;
	  ▪ Is within one of the following categories:
	  ▪ Amblyopia;
	  ▪ Post surgical eye condition;
	  ▪ Diminished or subnormal vision; or
	  ▪ Other diagnosis which indicates the need for eyeglasses; and
	  ▪ Requires a prescription correction in the stronger lens no weaker than:
	  ▪ +0.50, 0.50 sphere +0.50, or 0.50 cylinder;
	  ▪ 0.50 diopter of vertical prism; or
	  ▪ A total of two (2) diopter of lateral prism.
	▪ Polycarbonate and scratch coating are covered.
	▪ Tinted lenses are covered when the prescription specifically indicates a diagnosis of photophobia.
	▪ Plano safety glasses are covered when medically indicated for the recipient.
	▪ The following is covered when medically necessary for:
	  ▪ Photochromics
	  ▪ Anti-reflective coating
	  ▪ Other lens options
	  ▪ Press-on prism

Eyeglass Replacements	▪ 1 pair every calendar year when:
	  ▪ The recipient's eyeglasses are broken or lost during the calendar year; or
	  ▪ The eyeglass prescription for the recipient is changed during the calendar year.
	▪ **To identify replacement materials, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for materials.**

Medically Necessary Contacts	▪ Contact lenses are covered in lieu of eyeglasses when a medical condition prevents the use of eyeglasses.